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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

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APPLICATION FOR VOLUNTEER LICENSE TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF DELAWARE

Please type or legibly print all information.

IDENTIFICATION:

Name: _____
Last First Middle

Name (if different from above): _____
Last First Middle

Mailing Address:

_____

_____

City State Zip

Phone: (Home)_____ (Work)_____

Email Address: _____

Date of Birth (MM/DD/YY) _____/_____/_____ SSN _____-_____-_____

Do you intend on utilizing the Federation Credentials Verification Service (FCVS) to provide the Delaware Board of Medical Practice with your Physician Information Profile? Yes _____ No_____

EDUCATION:

Medical Education:

School	Location	Dates	Degree

If a graduate of a foreign medical school, please indicate your ECFMG number and complete the Request for Status Report of ECFMG[SM] Certification:

USMLE/ECFMG Identification Number: 0-_____

Pursuant to Section 7 of the Privacy Act of 1974, you are hereby given notice that the disclosure of your social security number on this application is required by 29 *Del. C.* §8735(m). It may be used to enforce child support obligation pursuant to 13 *Del. C.* §2216 and for other lawful purposes.

Applicant Name: _____

Post Graduate Training:

Hospital/Institution	Location	Dates	Specialty

Area / Field of Specialization	Board eligible?	Board Certified?
_____	Yes ( ) No ( )	Yes ( ) No ( )
_____	Yes ( ) No ( )	Yes ( ) No ( )
_____	Yes ( ) No ( )	Yes ( ) No ( )

1. Have you ever taken any of the following examinations: Yes ( ) No ( )
USMLE, FLEX, National Boards or State Boards?

Examination	Date Passed Month/Year
ECFMG (Basic)	_____
ECFMG (Clinical)	_____
ECFMG (English)	_____
FLEX Component 1	_____
Flex Component 2	_____
Pre- 1985 FLEX	_____
USMLE Step 1	_____
USMLE Step 2	_____
USMLE Step 3	_____
NBME Part 1	_____
NBME Part 2	_____
NBME Part 3	_____
NBOME Part 1	_____
NBOME Part 2	_____
NBOME Part 3	_____
SPEX	_____
COMLEX Level 1	_____
COMLEX Level 2	_____
COMLEX Level 3	_____
LMCC	_____
*State Board Examination	_____

*(Name of state board(s) where examination was taken and passed) _____

2. Have you ever had a medical or professional license denied or revoked? Yes ( ) No ( )

List all states where you are **currently licensed**, or were **previously licensed**. **(Please include training license(s):**

State or Territory	License #	Effective Dates

3. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction? If yes, submit a certified copy of your criminal history record. Yes ( ) No ( )

4. Have you ever been professionally penalized for a drug related offense? Yes ( ) No ( )

5. Have you ever been professionally penalized or convicted of fraud? Yes ( ) No ( )

6. Have you ever violated the Medical Practice Act of another state? Yes ( ) No ( )

7. Have you ever been disciplined or had formal written action taken by a hospital staff or medical society, or licensing board of another state? Yes ( ) No ( )

8. Has a hospital, related health care facility, HMO, or alternative health care system denied your application for, or failed to renew your privileges; or limited, restricted, suspended, or revoked your privileges in any way? Yes ( ) No ( )

9. Are there any charges or complaints of any type including malpractice claims pending against you at present? Yes ( ) No ( )

10. Have you ever engaged in the practice of medicine without a license? Yes ( ) No ( )

11. Have you ever prescribed narcotic drugs unlawfully? Yes ( ) No ( )

12. Have you ever been convicted of a drug violation? Yes ( ) No ( )

13. Have you ever willfully violated the confidence of a patient? Yes ( ) No ( )

14. Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceedings or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, governmental agency, professional organization, or licensing authority? Yes ( ) No ( )

14.a. Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a mental, emotional, or nervous disorder or condition) which impairs your judgment or in any way currently affects, "or if untreated could affect," your ability to practice medicine in a fully competent and professional manner with safety to patients? If you answered yes, answer questions 13.b. and 13.c. If you answered no, continue on to question 14. Yes ( ) No ( )

14.b. Are such current conditions or impairments reduced or ameliorated because of ongoing treatment (with or without medication) or participation in a monitoring program or because of the field of practice, the setting, or the manner in which you have chosen to practice medicine? Yes ( ) No ( )

14.c. If you claim to have a mental or physical disability which limits your ability to practice medicine in a fully competent and professional manner with safety to patients, are you willing to accept a conditional or limited license to practice medicine if it is possible to accommodate such disability? Yes ( ) No ( )

15. Have you ever been denied a Drug Enforcement Agency (DEA) registration number or had one revoked or otherwise had your authority to write prescriptions limited or restricted? Yes ( ) No ( )

16. Do you agree to submit to an examination at Board expense should an examination be deemed necessary by the Executive Director of the Board of Medical Practice to determine if your physical and/or mental impairment presents a significant risk to the health or safety of patients or otherwise causes you not to be fully qualified to practice medicine in a competent and professional manner with safety to patients without limitations or accommodations? Yes ( ) No ( )

If you answered **YES** to any questions 2 – 15, or answered **NO** to question 16, please fully explain your answer(s) on a separate sheet(s)of paper, sign and swear to its truth before a notary, and attach it to this application. In addition, please provide any documentation from the state where this situation occurred, spelling out the issues, and any explanation you wish to provide.

Applicant Name: _____

Please note: When your application is complete, please allow 4-8 weeks to receive your license. A complete application is one that includes all required documentation and correct payment.

I, _____, swear that I am the person who executed this application; that the statements contained on this application are true in every respect; that I have not suppressed or withheld information that might affect this application; that I will abide by the laws and the ethical standards of this profession; and that I have read and understand this statement.

I further understand that by filing this application for a Certificate to Practice Medicine and Surgery in the State of Delaware, I hereby authorize and consent to have an investigation conducted to determine my professional qualifications, to determine if I have previously engaged in unprofessional conduct as defined in 24 Delaware Code §1731 or the Rules and Regulations of the Delaware Board of Medical Practice and to determine that I am physically and mentally capable of engaging in the practice of medicine with safety to the public.

I certify that I will perform no medical services for any direct compensation and volunteer my time in a nonprofit medical clinic or nonprofit medical service. I shall be responsible for completing the required amount of continuing education as established by the Board.

_____ _____
Signature of Applicant Date

Sworn to before me and subscribed in my presence this _____ day of _____, in the year of _____

Signature of Notary _____

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Delaware Board of Medical Practice any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or other pertinent data and to permit the Delaware Board of Medical Practice or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice thereunder.

I understand and acknowledge that the Board of Medical Practice will rely on the information I have provided in this application in making its determination on licensure. I hereby expressly agree to (1) keep the information I have provided in this application current until such time as the Board has finally acted on it, and (2) to promptly provide any and all additional information requested by or on behalf of the Board.

_____ _____
Signature of Applicant Date

Sworn to before me and subscribed in my presence this _____ day of

_____, in the year of _____

Signature of Notary

_____

Notary Seal